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## Healing in the Aftermath of War

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# **Problem Statement and Dissertation Structure**

The research collected in this dissertation presents a body of work aimed at enhancing an evidence-base for mental health and psychosocial<sup>1</sup> interventions for people exposed to political violence<sup>2</sup> in low-income contexts. The general objective of this research was to aid in having available a set of interventions that are maximally equipped to maintain or enhance psychosocial wellbeing in these populations.

## **POLITICAL VIOLENCE AND PSYCHOSOCIAL WELLBEING: PROBLEM STATEMENT**

Though mental health and psychosocial suffering during and after wars might be easily imagined, research and interventions aimed at relieving this suffering have not been given proper attention. Mental health and psychosocial interventions in low-income settings, on the whole, receive little funding from governments and international donors, and mental health policies are seldom in place in low- and middle-income countries [1,2]. These facts stand in sharp contrast to recent publications that have examined which health problems cause disability worldwide [3,4]. Rather than focus on mortality as an indicator of the burden of disease, the consideration of disability, through the calculation of the Disability Adjusted Life Year (DALY), has exposed the immense burden mental health problems place on individuals and societies (see also [5,6]). For example, the calculations from 1990 [3] showed that mental health problems contributed 8.1 percent to the global burden of disease, which is more than malaria (2.6%), heart disease (4.4%), or cancer (5.8%) [7]. More recent calculations based on data from 2001 show that in low- and middle-income countries this percentage was 11.1%. Moreover, neuropsychiatric conditions were the largest contributors to the amount of years lived in states of less than full health in all regions of the world [4].

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<sup>1</sup> The terms mental health and psychosocial wellbeing refer to relatively similar constructs. Mental health has been defined as “not simply the absence of detectable mental disease but a state of wellbeing in which the individual realizes his or her own abilities, can work productively and fruitfully, and is able to contribute to her or his community ([7]; p. 7). Similarly, current use of the adjective psychosocial is intended to emphasize connections between psychological variables (cognition, emotion, behaviour) and socio-cultural context [41]. In humanitarian practice, however, the terms have been used by different actors inside and outside the health sector. In accordance with current consensus, I have aimed to use the terms together, unless referring to work within a specific discipline [24].

<sup>2</sup> In the World Health Organization (WHO) [8] typology of violence, collective violence is “inflicted by larger groups such as states, organized political groups, militia groups and terrorist organizations” ([8]; p. 6). Collective violence is further subdivided into social, political, and economic violence, and “the subcategories of collective violence suggest possible motives for violence committed by larger groups of individuals or by states. ... Political violence includes war and related violent conflicts, state violence, and similar acts carried out by larger groups.” ([8]; p. 6)

Violence has been studied as an important risk factor for deteriorated health in general, and mental illness in particular [7,8]. The World Health Assembly has described violence as a global public health priority - not surprising given the 9.3 war-related deaths per 100,000 people globally in 1990 [9]. Currently, the majority of political violence occurs in low- and middle-income contexts [10]. The conclusion of the World Mental Health report, a two-year collaborative research effort surveying the burden of problems related to mental, social, and behavioral health problems in low- and middle-income settings, recommends "that broad initiatives be developed to attend the causes and consequences of collective and interpersonal violence" ([7]; p. 276).

However, until now very little research takes place within the developing world; in the last 10 years only 6% of research published on mental health came from low- and middle income countries [11]. As part of the recent series on global mental health in the medical journal the Lancet, Patel and colleagues reviewed the evidence available regarding prevention and treatment of mental disorders in low- and middle-income countries. They concluded that the evidence base for interventions for those exposed to conflict and disasters is weak [12]. Similarly, for specific target groups such as torture survivors and children affected by armed conflict, a number of authors have pointed to the paucity of research evaluating interventions [13-15], even though children comprise 35-50% of the population in low- and middle-income countries [16]. Major difficulties associated with doing research on political violence-exposed populations in low- and middle income countries include (a) the absence of mental health professionals to implement research, (b) the challenge of working with disease constructs and treatment modalities originating in different socio-cultural backgrounds, (c) threats to safety of research staff, (d) rapid contextual changes associated with political violence, including displacement of populations and the breakdown of infrastructure (e.g. economic, transport, governance infrastructure), (e) the ethical dilemma of choosing between service provision (of unknown efficacy) and research implementation in situations of massive needs and strained resources, and until recently, (f) the lack of consensus within the academic and humanitarian fields concerning appropriate mental health and psychosocial support in emergencies (see e.g. [14,17,18]). In the existing literature, the dominant focus has often been on describing the impact of mental health on individuals, mostly in terms of psychiatric classification systems developed in high-income settings [19,20].

## **NEPAL AND INDONESIA: BACKGROUND AND SETTING**

Nepal's and Poso's (Indonesia) political histories and settings are described in more detail in chapter 5 and 6 respectively. In short, both Asian settings are exemplars of the post-Cold War trend of increasing internal conflicts in civilian populated areas,

rather than armed conflicts between states in defined battle zones [21]. This shift in the practice of warfare increases health risks for civilian populations; UNICEF reports that between 1986 and 1996 two million children were killed in combat, and between four and five million disabled [22]. In addition, most political violence takes place in low- and middle-income countries, i.e. it occurs in situations of chronic poverty, food insecurity, and asymmetrical distribution of scarce resources [10]. In Nepal research took place in the context of a decade-long Maoist insurgency (1996-2006), rooted in poverty, unequal division of wealth, ethnic, regional and caste discrimination, disappointment with state governance and violent state responses to the Maoist movement. In Indonesia, political violence consisted of armed violence between Christian and Muslim groups from 1998, in the context of changing economic relations and remnants of a colonial history, state-sponsored migration and decentralization, and a weak state structure.

## RESEARCH FOCI

The studies in this dissertation were aimed at narrowing the above mentioned gap in knowledge, and addressing a number of challenges researchers confront when doing research with populations affected by political violence in low- and middle income countries. More specifically, the studies included in this dissertation targeted the following research questions:

- How can the impact of political violence on psychosocial wellbeing and mental health best be described?
- What are appropriate psychosocial and mental health intervention strategies for populations affected by political violence?
- How effective are current psychosocial and mental health intervention strategies?

Considerable debate has surrounded all three of these research questions, specifically concerning the appropriateness of a focus on Posttraumatic Stress Disorder and the importance of cultural context [20,23]. A major milestone has been the recent publication of a consensus statement. This statement represents the consensus of a large collection of (international) non-governmental and United Nations organizations [24]. Although this is indeed a great step forwards, closer scientific scrutiny of the evidence base shows that there are currently but few rigorous scientific findings that support this consensus [25]. Unfortunately, the scientific history in this field has shown that such evidence is needed, even in the case of expert consensus, wide implementation, and positive anecdotal evidence. Psychological debriefing, for instance, was considered a standard response in the aftermath of exposure to traumatic stressors to prevent posttraumatic stress symptoms, and participants generally reported it to be beneficial. Subsequent research on its efficacy, however, has shown that debriefing did not prevent posttraumatic

stress symptoms and in cases could do harm [26,27]. In other words, despite emerging consensus, there remains an enormous gap in knowledge.

## STRUCTURE OF DISSERTATION

After this introductory chapter, the dissertation consists of two distinct parts, both organized according to the research questions outlined above. The first half of this dissertation addresses these with adult torture survivors in Nepal, and the second half addresses these research questions with children affected by communal violence in Indonesia.

The first part starts with a chapter that presents research on the impact of torture on rural populations in Nepal through the use of a cross-sectional design (*chapter 2*). Because of the debate on the appropriateness of a focus on Posttraumatic Stress Disorder and other syndromes categorized in psychiatric classification systems from high-income settings, this research addressed the question of the relevance of psychiatric symptom categories in terms of their relation with disability in daily life. Current screening for mental problems often entails the use of symptom checklists that do not include the assessment of disability, even though the DSM-IV and ICD-10 specify this as a precondition for assessment [28,29]. The second chapter (*chapter 3*) provides a conceptual review of cultural challenges encountered during the practice of psychosocial counseling. Psychosocial counseling was taken up in Nepal, as in other countries, as a way to deal with a large psychosocial distress and mental health burden in the absence of trained professionals to deal with these problems [30-32]. Subsequently, a non-randomized controlled study is presented which was aimed at evaluating the effectiveness of a multi-disciplinary treatment, encompassing psychosocial counseling, to improve psychosocial wellbeing (*chapter 4*). This part of the dissertation ends with a systematic multi-disciplinary review of the literature on the relations between political violence, psychosocial wellbeing and mental health in Nepal, aimed at placing the problem of torture as a human rights concern in a broader context. This chapter also recommends ways forward for policy makers and researchers who concern themselves with political violence in Nepal (*chapter 5*).

The second part of the dissertation has a similar structure. The first two chapters address the question of how the psychosocial and mental health impact of political violence can best be conceptualized. In the first chapter, qualitative research is presented which aimed at describing the consequences of armed violence in Poso, Indonesia, based on the perspectives of children, families and community members themselves (*chapter 6*). The second chapter (*chapter 7*) describes the design of research methodology, combining qualitative and quantitative data collection, that was developed to ensure the culturally valid measurement of child function impairment. *Chapter 8* focuses

on how treatment for conflict-affected children can best be conceptualized. The chapter proposes an ecological model, based on qualitative research and a selective review of the literature, which emphasizes influences of the larger socio-cultural context on children's wellbeing. *Chapter 9* presents a cluster randomized trial that was designed to assess the efficacy of a school-based psychosocial program to increase the wellbeing of violence-affected children. Similar to the first part of the dissertation, this second part concludes with a chapter that aims at charting ways forward. This chapter discusses methodological advances to assess the working mechanisms of treatment. Knowledge about the working mechanisms, in our opinion, is essential for the improvement of psychosocial interventions for these populations (*chapter 10*).

#### Two target groups: a paradigm shift in progress

The fact that the dissertation consists of research on these two different target groups reflects the praxis of this scientific field in two ways. First, it simply reflects the above-mentioned reality that research in this field is under-funded. The possibility to do research is often dependent upon funding from external (international) actors engaged in humanitarian or development funding. Though it was initially intended to continue research in Nepal, funding became restricted and assistance to torture survivors took preference over research. At the same time, the non-governmental organization I was working with in the Netherlands received funding for a multi-country intervention-research project for children affected by armed conflicts outside of Nepal.

Second, the research on these two different target groups indirectly reflects the changing interests and scope of this field of science and practice. One of the initial foci of work with international populations affected by political violence was care for torture survivors. In the 1980's, rehabilitation centers for torture survivors were erected in both Western and developing nations [33]. Though services were often multi-disciplinary, and in spite of the recognition of shortcomings by the movement, the initial focus of much of this work emphasized the Posttraumatic Stress Disorder, a psychiatric symptom category first included in the Diagnostic Statistical Manual in 1980 [34], as an important psychological outcome of torture. This focus reflected a general dominance of biomedical perspectives on intervention and research with political violence-affected populations, also with refugees in high-income settings (for an early critique see [35]).

Early critique criticized this biomedical focus, on accounts of Western cultural notions underpinning psychiatric classification systems and treatment, e.g. notions of individualism, the separation of body and mind, and a focus on the intra-psycho rather than social or supernatural explanations of illness [36,37]. Currently, although a biomedical focus might still be dominant, most practitioners and academicians in this field highlight the importance of the role of the socio-cultural context [5,14,38,39]. The work of the Psycho-

social Working group represents well this current integration of insights from the social science literature [40,41], as does current consensus on psychosocial and mental health responses in emergency settings [24]. At the moment, there seems to be an increasing trend for trans-disciplinary and multi-disciplinary interaction in describing the effects of adverse events on psychosocial wellbeing, between the disciplines of anthropology/sociology, psychiatry, clinical psychology and public health (e.g. [37,42,43]). I will come back to this in more detail in the epilogue of this dissertation.

My personal trajectory while working on research for this dissertation mirrors these changing paradigms. I first started being involved in this field of science and practice for a Masters Degree thesis in Clinical and Health Psychology (2001), which questioned aspects of the validity of the Posttraumatic Stress Disorder for torture survivors in Nepal. This research was done within a clinic-based setting, with the Centre for Victims of Torture, Nepal (CVICT), while I was involved with the Transcultural Psychosocial Organization (TPO, now merged to form HealthNet TPO). CVICT is part of a group of torture rehabilitation centers associated with the International Rehabilitation Council for Torture Victims (IRCT) based in Copenhagen, Denmark. At this point my attention was focused on a population that often displayed specific mental health complaints and was in need of more specialized care (i.e. tertiary prevention). At the end of 2004, however, I started coordinating research within a project for children affected by political violence in Burundi, Indonesia, and Sri Lanka for HealthNet TPO. A central element of this project was a school-based intervention for children at risk of developing psychiatric problems. In other words, my attention shifted a) from tertiary prevention to secondary prevention, b) from adults to children, and c) from a clinic-based setting to a community-based setting. As the chapters of this dissertation show, this resulted in increased consideration of the socio-cultural context in which the psychosocial consequences of political violence emerge and, accordingly, a methodological shift to combining qualitative and quantitative methodology – a shift towards a more multidisciplinary way of working.



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